26. Personal care services. (continued)

option of shared services; if accepted, the recipient or responsible party may withdraw participation in shared services at any time.

In addition to the documentation requirements for personal care provider service records in state rule, a personal care provider must meet documentation requirements for shared services and must document the following in the health service record for each recipient sharing services:

a) permission by the recipient or responsible party for the maximum number of shared services hours per week chosen by the recipient;

b) permission by the recipient or responsible party for personal care assistant services provided outside the recipient's home;

c) permission by the recipient or responsible party for others to receive shared services in the recipient's home;

d) revocation by the recipient or responsible party of the shared service authorization, or the shared service to be provided to others in the recipient's home, or the shared services to be provided outside the recipient's home;

e) supervision of the shared personal care assistant services by the qualified professional, including the date, time of day, number of hours spent supervising the provision of share services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, and shared services scheduling issues and recommendations;

26. Personal care services. (continued)

f) documentation by the qualified professional of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient; and

g) daily documentation of the shared services provided by each identified personal care assistant including:

1) the names of each recipient receiving share services together;

2) the setting for the shared services, including the starting and ending times that the recipient received shared services; and

3) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional.

In order to receive shared services:

a) the recipient or responsible party, in conjunction with the county public health nurse, must determine:

1) whether shared services is an appropriate option based on the individual needs and preferences of the recipient; and

2) the amount of shared services allocated as part of the overall authorization of personal care services;

b) the recipient or responsible party, in conjunction with the supervising qualified professional, must arrange the setting, and grouping of shared services based on the individual needs and preferences of the

26. Personal care services. (continued)

recipients;

c) the recipient or responsible party, and the supervising qualified professional, must consider and document in the recipient's health service record:

1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;

2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are appropriately and safely met. The provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter;

3) the setting in which the shared services will be provided;

4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and

5) a contingency plan which accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.

- The following personal care services are covered under medical assistance as personal care services:

a) bowel and bladder care;

b) skin care to maintain the health of the skin;

26. Personal care services. (continued)

c) repetitive range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

d) respiratory assistance;

e) transfers and ambulation;

f) bathing, grooming, and hair washing necessary for personal hygiene;

g) turning and positioning;

h) assistance with furnishing medication that is self-administered;

i) application and maintenance of prosthetics and orthotics;

j) cleaning medical equipment;

k) dressing or undressing;

l) assistance with eating, meal preparation and necessary grocery shopping;

m) accompanying a recipient to obtain medical diagnosis or treatment;

n) effective July 1, 1996, assisting, monitoring, or prompting the recipient to complete the services in items (a) to (m);

o) effective July 1, 1996, redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care described in items (a) to (n);

p) effective July 1, 1996, redirection and intervention for behavior, including observation and monitoring;

26. Personal care services. (continued)

q) effective July 1, 1996, interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

r) effective July 1, 1998, tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure may be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean, rather than a sterile procedure, and must ensure that the personal care assistant has been taught the proper procedure. A clean procedure is defined as a technique reducing the numbers of microorganisms, or prevents or reduces the transmission of microorganisms from one recipient or place to another. It may be used beginning 14 days after insertion; and

s) incidental household services that are an integral part of a personal care service described in items a) to r).

- The above limitations do not apply to medically necessary personal care services under EPSDT.

- The following services are not covered under medical assistance as personal care services:

a) a health service provided and billed by a provider who is not an enrolled personal care provider;

b) personal care service that is provided by a person who is the recipient's spouse, legal guardian for an adult or child recipient, parent of a recipient under age 18, or the recipient's responsible party;

26. Personal care services. (continued)

c) effective July 1, 1996, services provided by a foster care provider of a recipient who cannot direct his or her own care, unless a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met;

d) services provided by the residential or program license holder in a residence for more than four persons;

e) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

f) sterile procedures;

g) giving of injections of fluids into veins, muscles, or skin;

h) homemaker services that are not an integral part of a personal care service;

i) home maintenance or chore services;

j) personal care services that are the responsibility of the foster care provider;

k) personal care services when the number of foster care residents is greater than four;

l) personal care services when combined with home health services, private duty nursing services, and foster care payments that exceed the total amount that public funds would pay for the recipient's care in a medical institution. This is a utilization control limitation conducted on a case-by-case basis in order to provide the recipient with the most cost-effective, medically appropriate services;

26. Personal care services. (continued)

m) services not specified as covered under medical assistance as personal care services;

n) effective January 1, 1996, assessments by personal care provider organizations or by independently enrolled registered nurses;

o) effective July 1, 1996, services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided (applies to foster care settings);

p) effective January 1, 1996, personal care services that are not in the service plan;

q) home care services to a recipient who is eligible for Medicare covered home care services (including hospice), if elected by the recipient, or any other insurance held by the recipient;

r) services to other members of the recipient's household;

s) any home care service included in the daily rate of the community-based residential facility where the recipient resides;

t) personal care services that are not ordered by the physician; or

u) services not authorized by the commissioner or the commissioner's designee.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 5 to this Attachment.

- Not provided.

SUPPLEMENTARY NOTES

The following services are not covered under the Medical Assistance program:

1. a health service paid for directly by any other source, including third-party payers and recipients, unless the recipient's eligibility is retroactive and the provider bills the Medical Assistance program for the purpose of repaying the recipient;

2. drugs which are not in the Drug Formulary or which have not received prior authorization;

3. a health service for which the required prior authorization was not obtained;

4. autopsies;

5. missed or canceled appointments;

6. telephone calls or other communications that were not face-to-face between the provider and the recipient;

7. reports required solely for insurance or legal purposes unless requested by the local agency or the Department;

8. an average procedure including cash penalties from recipients, unless provided according to state rules;

9. a health service that does not comply with Minnesota Rules, parts 9505.0170 to 9505.0475

10. separate charges for the preparation of bills;

11. separate charges for mileage for purposes other than medical transportation of a recipient;

12. a health service that is not provided directly to the recipient, unless the service is a covered service;

SUPPLEMENTARY NOTES (continued)

13. concurrent care by more than one provider of the same type of provider or health service specialty, for the same diagnosis, without an appropriate medical referral detailing the medical necessity of the concurrent care, if the provider has reason to know concurrent care s being provided. In this event, the Department shall pay the first submitted claim;

14. a health service, other than an emergency health service, provided to a recipient without the knowledge and consent of the recipient or the recipient's legal guardian, or a health service provided without a physician's order when the order is required by state rules, or a health service that is not in the recipient's plan of care;

15. a health service that is not documented in the recipient's health care record or medical record as required by state rules;

16. a health service other than an emergency health service provided to a recipient in a long-term care facility and which is not in the recipient's plan of care or which has not been ordered, in writing, by a physician when an order is required;

17. an abortion that does not comply with 42 CFR §§441.200 to 441.208 or Minnesota Statutes, §256B.0625, subdivision 16;

18. a health service that is of a lower standard of quality than the prevailing community standard of the provider's professional peers. In this event, the provider of service of a lower standard of quality is responsible for bearing the cost of the service;

19. a health service that is only for a vocational purpose or an educational purpose that is not related to a health service;

SUPPLEMENTARY NOTES (continued)

20. except for an emergency, more than one consultation by a provider per recipient per day; for purposes of this item, "consultation" means a meeting of two or more physicians to evaluate the nature and progress of disease in a recipient and to establish the diagnosis, prognosis, and therapy;

21. except for an emergency, or as allowed in item 22, more than one office, hospital, long-term care facility, or home visit by the same provider per recipient per day;

22. more than one home visit for a particular type of home health service by a home health agency per recipient per day, except as specified in the recipient's plan of care;

23. record keeping, charting, or documenting a health service related to providing a covered service;

24. services for detoxification which are not medically necessary to treat an emergency;

25. artificial insemination;

26. reversal of voluntary sterilization;

27. surgery primarily for cosmetic purposes;

28. ear piercing; and

29. gender reassignment surgery and other gender reassignment medical procedures, including drug therapy for gender reassignment (unless the recipient began receiving such services before July 1, 1998).

2.a. Outpatient hospital services.

Payments for outpatient hospital services may not exceed in aggregate the total payments that would have been paid under Medicare.

Outpatient hospital services are paid as follows:

Emergency room operating charges are paid the lower of:

(1) submitted charge; or

(2) 114.04% of the 1990 average submitted charge:

a) Anesthesia supplies and materials are paid at $204.59.

b) Oxygen supplies are paid at $40.07.

c) Post-anesthesia observation is paid at $73.41 per 15 minute unit of service up to four hours.

d) Post-emergency care bed is paid at $28.51 per 15 minute unit of service up to four hours.

Miscellaneous outpatient hospital facility component charges are paid the lower of:

(1) submitted charge; or

(2)
- prolonged outpatient IV therapy = $36.63
- mental health observation bed = $28.58
- external fetal monitoring, four hours or less = $56.27
- external fetal monitoring, more than four hours $117.25
- end-stage renal disease hemodialysis for outpatient, per treatment = submitted charge (through May 31, 1994)
- end-stage renal disease hemodialysis for outpatient, per treatment = in accordance with composite rate methodology for the Medicare program, regardless of service date (as of June 1, 1994)

Ambulatory surgical center facility services or facility components are paid in accordance with the methodology in item 6.d.C., Ambulatory surgical centers.

2.a. Outpatient hospital services. (continued)

The **emergency room facility charge** is paid the lower of:

(1) submitted charge; or
(2)(a) provider's cost for a 15 minute unit of services based on a 1983 cost report plus 42.56%; or
(b) if the provider did not submit a cost report, $35.64 for each 15 minute unit of service.

The **clinic facility charge** is paid the lower of:

(1) submitted charge; or
(2)(a) $35.64 for urgent care facility fee; or
(b) $25.43 for all other clinic facility fees.

Other outpatient hospital services as paid using the same methodology in item 5.a., Physicians' services.

Laboratory services are paid using the same methodology in item 3, Other laboratory and x-ray services.

Vaccines are paid the lower of:

(1) submitted charge; or
(2) the average wholesale price plus $1.50 for administration.

Vaccines available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid the lower of:

(1) submitted charge; or
(2) the $8.50 administration fee.

All other injectables are paid the lower of:

(1) submitted charge; or
(2) the average wholesale price.

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

For level one HCPCS codes titled "office and other outpatient services", "preventive medicine new and established patient", "delivery, antepartum and postpartum care", "critical care", "cesarean delivery" and "pharmacological management" provided to psychiatric patients; and HCPCS level three codes for enhanced services for prenatal high risk, payment is the lower of:

(1) submitted charges; or

(2) (a) 80% of the 50th percentile of the charges submitted by all providers of the service (except for services provided by home health agencies, home and community based waiver services providers, IEP providers, dentists, and providers whose payment rate is based on a percentage of the physicians' payment rate) in the calendar year specified in legislation governing maximum payment rates; or

(b) State agency established rate.

Effective January 1, 2000, the rate is increased by three percent.

For all other services the payment rate is the lower of:

(1) submitted charges; or

(2) (a) 75% of the 50th percentile of the charges submitted by all providers of the service (except for services provided by home health agencies, home and community based waiver services providers, IEP providers, dentists, and providers whose payment rate is based on a percentage of the physicians' payment rate) in the calendar year specified in legislation governing maximum payment rates; or

(b) State agency established rate.

Effective January 1, 2000, the rate is increased by three percent.

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

Effective July 1, 1997, the State agency established rate is increased five percent for physical therapy services, occupational therapy services, speech-language therapy services, and respiratory therapy services. Effective July 1, 1998, the rate is increased three percent for these services, and effective January 1, 2000, the rate is increased another three percent.

The rates for respiratory therapy services are as follows:

Procedure Code	**Rate**
94640	$ 15.02
94642	19.02
94650	16.70
94651	14.48
94652	140.34
94656	100.24
94657	43.43
94660	100.24
94664	18.78
94665	12.93
94667	16.19
94668	16.19

If the service is provided by ~~a~~ an **enrolled physician assistant**, the ~~supervising enrolled provider~~ service is paid the lower of:

1) submitted charge; or

2) 90% of the reference file allowable.

If the service is provided by a **physician extender**, the ~~supervising enrolled provider~~ service is paid the lower of:

1) submitted charge; or

2) 65% of the reference file allowable, except for psychology services ~~which~~ that are provided by a nonenrolled mental health practitioner, in which case the ~~supervising enrolled provider~~ service is paid the lower of the submitted charge or 50% of the ~~enrolled provider~~ reference file allowable.

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

Psychotherapy services are paid the lower of:

(1) submitted charge; or

(2) (a) 75% of the 50th percentile of the charges submitted by all providers of the service (except for services provided by home health agencies, home and community-based waiver services providers, IEP providers and providers whose payment rate is based on a percentage of the physicians' payment rate) in the calendar year specified in legislation governing maximum payment rates; or

(b) State agency established rate.

Effective January 1, 2000, the rate is increased by three percent.

If the service is provided by a nonenrolled mental health practitioner, the supervising enrolled provider is paid the lower of:

(1) submitted charge; or

(2) 50% of item (2)(a) or (2)(b), above, for psychotherapy services.

Anesthesia services personally performed by the ~~physician~~ anesthesiologist are paid the lower of:

(1) submitted charge, or

(2) the product of the physician conversion factor ($18.00) multiplied by the sum of the relative base value units and time units (one time unit equals fifteen minutes).

If the anesthesiologist medically directs one nurse anesthetist, the anesthesiologist is paid for the service as though it were personally performed.

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

If the anesthesiologist medically directs two to four concurrent anesthesia procedures performed by nurse anesthetists, the anesthesiologist is paid as follows:

(1) For two concurrent procedures: 90% of the relative base value multiplied by the physician conversion factor, plus time.
(2) For three concurrent procedures: 75% of the relative base value multiplied by the physician conversion factor, plus time.
(3) For four concurrent procedures: 60% of the relative base value multiplied by the physician conversion factor, plus time.

For items (1), (2) and (3), if the nurse anesthetists are employed by the anesthesiologist, time is paid at $2.40 per minute. If the nurse anesthetists are not employed by the anesthesiologist, time is paid at $1.20 per minute.

If the anesthesiologist directs (supervises) five or more nurse anesthetists, the anesthesiologist is paid the physician conversion factor multiplied by four.

Anesthesia services provided by anesthesiologist supervising residents or student registered nurse anesthetists are paid:

$$\frac{(\text{relative base value units} + \text{time units}) \times 18.00}{2} \times 1.862$$

Laboratory services are paid using the same methodology as item 3, Other lab and x-ray services.

With the exception of pediatric vaccines in item 2.a., Outpatient hospital services, covering the Minnesota Vaccines for Children program, **vaccines** are paid using the same methodology as item 2.a., Outpatient hospital services.

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

All other injectables are paid using the same methodology as item 2.a.

❒ monitoring for identification and lateralization of cerebral seizure focus by attached electrodes;

combined electroencephalographic (EEG) and video recording and interpretation each 24 hours are paid the lower of:

(1) submitted charge; or
(2) $751.90

The State has established a rate for the following:

	Procedure Code	Rate
(1)	92340	$ 28.84
(2)	92341	33.99
(3)	V5090	182.15
(4)	V5110	273.23
(5)	V5160	273.23
(6)	V5200	182.15
(7)	V5240	273.23
(8)	X5061	182.15

6.d. Other practitioners' services. (continued)

E. **Nurse practitioner services** (independently enrolled) are paid the lower of:

1) submitted charge; or

2) 90% of the rate established for a physician providing the same procedure.

Nurse practitioner services ~~(non-independently enrolled)~~ (physician extenders) are paid the lower of:

1) submitted charge; or

2) 65% of the rate established for a physician providing the same procedure.

If the services are paid through the payment for inpatient services, the nurse practitioner cannot separately bill for payment.

Laboratory, radiology, immunization, injection and allergy services are paid using the same methodology set forth elsewhere in this Attachment. EPSDT invoices are paid using the same methodology as item 4.b., Early and periodic screening, diagnosis, and treatment services.

Nurse practitioners who administer pediatric vaccines in item 2.a., Outpatient hospital services, available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid using the same methodology in item 2.a. for these vaccines.

6.d. Other practitioners' services. (continued)

H. **Clinical nurse specialist** services (independently enrolled) are paid the lower of:

1) submitted charge; or

2) 90% of the rate established for a physician providing the same procedure.

Clinical nurse specialist services (physician extenders) are paid the lower of:

1) submitted charge; or

2) 65% of the rate established for a physician providing the same procedure.

Clinical nurse specialist services provided by a **masters prepared nurse with American Nurses Association certification as a clinical specialist in psychiatric or mental health** are paid as provided in item 6.d.A.

Laboratory, radiology, immunization, injection and allergy services are paid using the same methodology set forth elsewhere in this Attachment. EPSDT invoices are paid using the same methodology as item 4.b., Early and periodic screening, diagnosis, and treatment services.

Clinical nurse specialists who administer pediatric vaccines in item 2.a., Outpatient hospital services, available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid using the same methodology in item 2.a. for these vaccines.

7. Home health services.

See items 7.a. through 7.d.

7.a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Payment is the lower of:

1) submitted charge; or

2) Medicare cost-per-visit limits based on Medicare cost reports submitted by free-standing home health agencies in the Minneapolis and St. Paul area in the calendar year specified in state legislation governing maximum payment rates.

Effective July 1, 1994, this payment rate is increased by three percent.

Procedure Code	July 1, 1997	July 1, 1998	July 1, 1999
X5284 Skilled Nurse Visit	$52.79/visit	$54.37/visit	$56.54/visit

Immunizations and other injectables are paid using the same methodology as Item 2.a., Outpatient hospital services.

Home health agencies that administer pediatric vaccines in item 2.a., Outpatient hospital services, available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid using the same methodology in item 2.a. for these vaccines.

7.b. Home health aide services provided by a home health agency.

Payment is the lower of:

1) submitted charge; or

2) Medicare cost-per-visit limits based on Medicare cost reports submitted by free-standing home health agencies in the Minneapolis and St. Paul area in the calendar year specified in state legislation governing maximum payment rates.

Effective July 1,1994, this payment rate is increased by three percent.

Procedure Code	July 1, 1997	July 1, 1998	July 1, 1999
X5285 Home Health Aide Visit	$40.50/visit	$41.72/visit	$43.39/visit

7.c. Medical supplies, equipment, and appliances suitable for use in the home.

Hearing aids, eyeglasses and oxygen are purchased on a volume basis through competitive bidding.

Medical supplies and equipment that are not purchased on a volume basis are paid the lower of:

(1) submitted charge;
(2) Medicare fee schedule amount for medical supplies and equipment; or
(3) if Medicare has not established a payment amount for the medical supply or equipment, an amount determined using one of the following methodologies:

(a) 50th percentile of the usual and customary charges submitted for the medical supply or equipment for the previous calendar year minus 20 percent;
(b) if no information about usual and customary charges exists for the previous calendar year, payment is based upon the manufacturer's suggested retail price minus 20 percent; or
(c) if no information exists about manufacturer's suggested retail price, payment is based on cost (wholesale) plus 20 percent.

Augmentative and alternative communication device manufacturers and vendors are paid the manufacturers's suggested retail price.

Enteral products are paid the lower of:

(1) submitted charge;
(2) Medicare fee schedule amount for enteral products; or
(3) if Medicare has not established a fee schedule amount, average wholesale price plus 26 percent.